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8
9 **BEFORE THE**
BOARD OF PHARMACY
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 4345

12 **DEBRA MAE GALEA**
12491 Castle Court Drive
13 Lakeside, CA 92040

14 **Pharmacy Technician Registration No. TCH**
15 **76174**

A C C U S A T I O N

16 Respondent.

17 Complainant alleges:

18 **PARTIES**

19 1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity
20 as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.

21 2. On or about May 24, 2007, the Board of Pharmacy issued Pharmacy Technician
22 Registration Number TCH 76174 to Debra Mae Galea (Respondent). The Pharmacy Technician
23 Registration was in full force and effect at all times relevant to the charges brought herein and
24 will expire on September 30, 2014, unless renewed.

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4. Section 4300 of the Code states in part:

(b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:

(2) Placing him or her upon probation.

(4) Revoking his or her license.

• • •

5. Section 118, subdivision (b), of the Code provides that the suspension, expiration, cancellation of a license shall not deprive the Board of jurisdiction to proceed with a new action during the period within which the license may be renewed, restored, reissued or replaced.

6. Section 4060 of the Code states:

2

1 to Section 3640.7, or furnished pursuant to a drug order issued by a
2 certified nurse-midwife pursuant to Section 2746.51, a nurse
3 practitioner pursuant to Section 2836.1, or a physician assistant
4 pursuant to Section 3502.1, or naturopathic doctor pursuant to
5 Section 3640.5, or a pharmacist pursuant to either subparagraph (D)
6 of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph
7 (5) of, subdivision (a) of Section 4052. This section shall not apply
8 to the possession of any controlled substance by a manufacturer,
9 wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist,
10 optometrist, veterinarian, naturopathic doctor, certified
11 nurse-midwife, nurse practitioner, or physician assistant, when in
12 stock in containers correctly labeled with the name and address of
13 the supplier or producer.

14 Nothing in this section authorizes a certified nurse-midwife, a nurse
15 practitioner, a physician assistant, or a naturopathic doctor, to order
16 his or her own stock of dangerous drugs and devices."

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19
20 7. Section 4301 of the Code states:

21 The board shall take action against any holder of a license who is
22 guilty of unprofessional conduct or whose license has been
23 procured by fraud or misrepresentation or issued by mistake.
24 Unprofessional conduct shall include, but is not limited to, any of
25 the following:

26 ...

27 (f) The commission of any act involving moral turpitude,
28 dishonesty, fraud, deceit, or corruption, whether the act is
committed in the course of relations as a licensee or otherwise, and
whether the act is a felony or misdemeanor or not.

(g) Knowingly making or signing any certificate or other document
that falsely represents the existence or nonexistence of a state of
facts.

...
(j) The violation of any of the statutes of this state, or any other
state, or of the United States regulating controlled substances and
dangerous drugs.

...
(o) Violating or attempting to violate, directly or indirectly, or
assisting in or abetting the violation of or conspiring to violate any
provision or term of this chapter or of the applicable federal and
state laws and regulations governing pharmacy, including
regulations established by the board or by any other state or federal
regulatory agency....

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1 8. Section 4324 of the Code states:

2 "(a) Every person who signs the name of another, or of a fictitious person, or falsely makes,
3 alters, forges, utters, publishes, passes, or attempts to pass, as genuine, any prescription for any
4 drugs is guilty of forgery and upon conviction thereof shall be punished by imprisonment in the
5 state prison, or by imprisonment in the county jail for not more than one year.

6 "(b) Every person who has in his or her possession any drugs secured by a forged
7 prescription shall be punished by imprisonment in the state prison, or by imprisonment in the
8 county jail for not more than one year."

9 9. Health and Safety Code section 11170 states that no person shall prescribe,
10 administer, or furnish a controlled substance for himself.

11 10. Health and Safety Code section 11173, subdivision (a) states:

12 No person shall obtain or attempt to obtain controlled substances, or
13 procure or attempt to procure the administration of or prescription
14 for controlled substances (1) by fraud, deceit, misrepresentation, or
subterfuge; or (2) by the concealment of a material fact.

15 **COST RECOVERY**

16 11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
17 administrative law judge to direct a licentiate found to have committed a violation or violations of
18 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
19 enforcement of the case.

20 **DRUGS**

21 12. **Hydrocodone bitartate/acetaminophen**, also known by the brand names Vicodin,
22 Norco, Zydone, Maxidone, Lortab, Lorcet, Hydrocet, Co-Gesic, and Anexsia, is a narcotic
23 Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4),
24 and is a dangerous drug pursuant to Business and Professions Code section 4022. Hydrocodone
25 is used as a narcotic analgesic in the relief of pain.

26 **FACTS**

27 13. Respondent was employed as a Pharmacy Technician at San Diego Hospice and the
28 Institute for Palliative Medicine ("SDHIPM") from November 7, 2007 until she was terminated

1 on or about May 4, 2011 for suspicion of diversion of controlled substances, to wit,
2 hydrocodone/acetaminophen 5/500 mg (also known as "Vicodin").

3 14. SDHIPM has 24 hospice beds with about 20-24 patients at all times. In addition, the
4 pharmacy serviced about 1000 hospice patients at their homes. For these patients, medication
5 was delivered through a carrier service.

6 15. At all times relevant to this Accusation, SDHIPM's pharmacy stored narcotics in two
7 places. All Schedule II controlled substances, all drugs containing hydrocodone, Sudafed,
8 Ambien and a few other drugs, were stored in the MedDispense automated dispensing machine.
9 Other drugs such as Xanax, Ativan, Restoril, phenobarbital and other drugs in this category were
10 stored in the Narcotic cabinet. Before April, 2011, SDHIPM used MedDispense to monitor
11 dispensing of controlled substances and ADT, which was a computer program that contained
12 patient information such as prescriptions, discharges and transfer records under the QS1 database.
13 A prescription refill or new prescription order for a controlled substance was entered into the QS1
14 database and a prescription label was generated. The pharmacist or pharmacy technician then
15 entered the patient's name, drug and quantity in MedDispense in order to withdraw the drug. If
16 the patient's name was not in the MedDispense database, the pharmacist had to enter the patient's
17 information in order for the system to allow access to medication. These two computer programs
18 were linked in April, 2011.

19 16. On April 19, 2011, MedDispense reported a discrepancy: a prescription for 120
20 tablets hydrocodone/acetaminophen 5/500 mg was filled for a deceased patient. The request for
21 home delivery for this patient was deleted and the delivery transaction voided however, the drugs
22 were not returned to pharmacy stock. This discrepancy prompted an investigation of the
23 preceding 12 months of data.

24 17. The investigation revealed that between October 21, 2010 and April 19, 2011, a total
25 of 35 prescription refills for hydrocodone/acetaminophen 5/500 mg totaling 4830 tablets were
26 processed. All of the 35 refill transactions were for in-home patients who were deceased.
27 However, the drugs were withdrawn from MedDispense and a delivery slip was generated. All
28 but 9 of the drug withdrawals were later cancelled in MedDispense but none of the drugs in these

35 transactions were returned to stock. All transactions were processed during the evening shift.
Respondent was the only staff member present when all of the 35 transactions occurred.

18. Of the 35 transactions between October 21, 2010 and April 19, 2011, the following
refill transactions were processed, drugs were withdrawn, and deliveries were cancelled but the
drugs were not returned to stock:

Patient	Date of Death	Rx Number	Date filled	Quantity
P.T.	10/21/10	4528202	10/21/10	120
		4528202	10/26/10	120
		4528202	11/22/10	120
		4528202	11/30/10	120
		4528202	12/29/10	120
		4528202	1/28/11	120
		4528202	2/9/11	120
B.J.	11/2/10	4528192	11/9/10	120
		4528192	11/15/10	120
		4528192	11/18/10	120
		4528192	12/6/10	120
		4528192	12/8/10	120
		4528192	12/14/10	120
		4528192	1/28/10	120
		4528192	4/19/10	120
J.B.	1/10/11	4529871	1/11/11	180
		4529871	1/13/11	180
		4529871	1/26/11	180
		4529871	2/7/11	180
		4529871	2/10/11	180
		4529871	3/1/11	180
		4529871	3/9/11	180
		4529871	3/17/11	180
		4529871	3/25/11	180
		4529871	3/30/11	180
A.D.	1/6/11	4530327	4/6/11	90
		4529649	4/11/11	90
W.C.	alive	4531093	4/29/11	120
			TOTAL	3900 tablets of hydrocodone/- acetaminophen 5/500 mg

1 19. On April 29, 2011, Respondent submitted a refill request from a nurse for
2 hydrocodone/acetaminophen 5/500 mg for patient W.C., a live patient, with a note to increase the
3 quantity from 60 to 120 tablets. The refill prescription was undated and was written by
4 Respondent. Further investigation showed that a request for delivery had cancelled, the delivery
5 carrier had not received the package for delivery but the drugs had not been returned to stock nor
6 was the package in the pharmacy cabinet waiting to be returned. MedDispense did not show the
7 drug as having been returned. In addition, W.C.'s nurse denied calling in a refill request.
8 Nursing notes two days before and after the request indicated W.C. had not complained of pain
9 and his occasional pain was relieved by over-the-counter Tylenol.

10 20. From October 21, 2010 through April 29, 2011, Respondent improperly, falsely, and
11 unlawfully, processed refill prescriptions for at least 3900 tablets of hydrocodone/acetaminophen
12 5/500 mg.

13 21. When confronted with these discrepancies by the R.P. and D.B., Respondent neither
14 admitted nor denied diverting the drugs, nor did she exhibit any surprise or anger at the
15 allegation.

16 22. Respondent's own controlled substance usage history from March 26, 2009 and
17 December 22, 2011 was obtained through the Controlled Substance Utilization Review and
18 Evaluation System (CURES). It showed that Respondent filled her own prescriptions for the
19 following drugs at Kaiser Pharmacy:

20 a.	Hydrocodone/acetaminophen 5/500 mg	150 tablets
21 b.	acetaminophen/codeine 30/300 mg	687 tablet
22 c.	Diazepam 10 mg	<u>30 tablets</u>
23	TOTAL:	867 tablets

24 23. Respondent's CURES report data shows that Respondent filled more prescriptions for
25 drugs containing hydrocodone or codeine after her termination on May 4, 2011. She obtained 60
26 tablets of hydrocodone/acetaminophen 5/500 mg in March and June 2009 but 717 tablets of drugs
27 containing hydrocodone or codeine in the 210 days between May 4, 2011 and December 22,
28 2011.

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct – Dishonesty, Fraud and Deceit)**

3 24. Respondent is subject to disciplinary action under Code section 4301(f) for
4 commission of any act involving moral turpitude, dishonest, fraud or deceit in that:

5 a. from October 21, 2010 through April 19, 2011, Respondent processed fraudulent
6 refill prescriptions for about 3780 tablets of hydrocodone/acetaminophen 5/500 mg for patients
7 who were deceased, as more fully set forth in paragraphs 13-18 and incorporated herein by this
8 reference; and

9 b. on or about April 29, 2011, Respondent wrote and processed a fraudulent telephonic
10 refill request for 120 tablets of hydrocodone/acetaminophen 5/500 mg for W.C. when no
11 telephonic request had been made by W.C.'s nurse, W.C. had not had any significant pain two
12 days before or after April 29, 2011 and W.C. was able to manage his occasional pain with over-
13 the-counter Tylenol, as more fully set forth in paragraph 19 and incorporated herein by this
14 reference.

15 **SECOND CAUSE FOR DISCIPLINE**

16 **(Unprofessional Conduct – Knowingly Making a Document**
17 **That Falsely Represents the Facts)**

18 25. Respondent is subject to disciplinary action under Code section 4301(g) for
19 knowingly making a document that falsely represents the existence of a state of facts when
20 Respondent wrote a refill prescription for W.C. under the guise of receiving a telephonic refill
21 request from W.C.'s nurse for 120 tablets of hydrocodone/acetaminophen 5/500mg, as more fully
22 set forth in paragraph 19 and incorporated herein by this reference.

23 **THIRD CAUSE FOR DISCIPLINE**

24 **(Unprofessional Conduct – Forging a Prescription)**

25 26. Respondent is subject to disciplinary action under Code section 4301(o), in
26 conjunction with Code section 4324, for forging a prescription when on or about April 29, 2011,
27 Respondent wrote a refill prescription for W.C. under the guise of receiving a telephonic refill
28

1 request from W.C.'s nurse for 120 tablets of hydrocodone/acetaminophen 5/500mg when no
2 telephonic request had been made by W.C.'s nurse, W.C. had not had any significant pain two
3 days before or after April 29, 2011 and W.C. was able to manage his occasional pain with over-
4 the-counter Tylenol, as more fully set forth in paragraph 19 and incorporated herein by this
5 reference.

6 **FOURTH CAUSE FOR DISCIPLINE**

7 **(Unprofessional Conduct – Unlawfully Possessing Controlled Substances)**

8 27. Respondent is subject to disciplinary action under Code section 4301, subdivisions
9 (j), for violating Code section 4060, in that Respondent unlawfully possessed, and/or furnished to
10 herself, controlled substances when Respondent processed fraudulent refill prescriptions for at
11 least 3900 tablets of hydrocodone/acetaminophen 5/500 mg from October 21, 2010 through April
12 29, 2011, as more fully set forth in paragraphs 13-20 and incorporated herein by this reference.

13 **FIFTH CAUSE FOR DISCIPLINE**

14 **(Unprofessional Conduct – Unlawfully Prescribing or Furnishing Controlled Substances)**

15 28. Respondent is subject to disciplinary action under Code section 4301, subdivisions
16 (o), for violating or attempting to violate, directly or indirectly, Health and Safety Code section
17 11170 regarding the unlawful prescribing or furnishing of controlled substances to herself, when
18 Respondent processed fraudulent refill prescriptions for at least 3900 tablets of
19 hydrocodone/acetaminophen 5/500 mg from October 21, 2010 through April 29, 2011, as more
20 fully set forth in paragraphs 13-20 and incorporated herein by this reference.

21 **SIXTH CAUSE FOR DISCIPLINE**

22 **(Unprofessional Conduct – Unlawfully Obtaining or Procuring
23 a Prescription for Controlled Substances)**

24 29. Respondent is subject to disciplinary action under Code section 4301, subdivisions
25 (o), for violating or attempting to violate, directly or indirectly, Health and Safety Code section
26 11173 regarding unlawfully obtaining or procuring a prescription for controlled substances by
27 fraud, misrepresentation or concealment of a material fact when Respondent processed fraudulent
28

1 refill prescriptions for at least 3900 tablets of hydrocodone/acetaminophen 5/500 mg from
2 October 21, 2010 through April 29, 2011, as more fully set forth in paragraphs 13-20 and
3 incorporated herein by this reference.

4 **PRAYER**

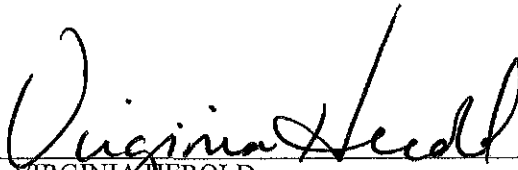
5 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
6 and that following the hearing, the Board of Pharmacy issue a decision:

7 1. Revoking or suspending Pharmacy Technician Registration Number TCH 76174,
8 issued to Debra Mae Galea;

9 2. Ordering Debra Mae Galea to pay the Board of Pharmacy the reasonable costs of the
10 investigation and enforcement of this case, pursuant to Business and Professions Code section
11 125.3; and,

12 3. Taking such other and further action as deemed necessary and proper.

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14
15 DATED: 12/14/12



VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

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